STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015552	A. BUILDING: _____ B. WING _____	R-C 01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY TERRACE MINOCQUA II	8730 B PACKING PLANT RD MINOCQUA, WI 54548

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 000}	Initial Comments On 01/24/2024, Surveyor conducted a verification visit and complaint (x2) investigation at Country Terrace Minocqua II. Data collection continued through 01/30/2024. Two deficiencies were identified. One of the 2 deficiencies was a repeat violation. See Statement of Deficiency (SOD) NB6611, dated 08/09/2023. Five of 6 deficiencies identified in SOD NB6611 were corrected. One of the 2 complaints was substantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 8	{N 000}		
N 356	83.32(3)(l) Rights of Residents: Least restrictive env In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Least restrictive environment. Have the least restrictive conditions necessary to achieve the purposes of the resident ' s admission. The CBRF may not impose a curfew, rule or other restriction on a resident ' s freedom of choice. This Rule is not met as evidenced by: Based on record review and interview, the provider restricted visiting hours for Resident 1. Findings include:	N 356		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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N 356	Continued From page 1 On 01/09/2024, the Department received a complaint alleging Resident 1's visiting hours were restricted during a visit with family on 01/08/2024. The provider is licensed to care for up to 10 residents in the following client groups: physically disabled, irreversible dementia/Alzheimer's disease, terminally ill, advanced age. On 01/24/2024, Surveyor reviewed Resident 1's file. Resident 1 was admitted on 10/04/2023. According to Resident 1's admission application, dated 10/02/2024, Resident 1 enjoyed being around others. On 01/24/2024 at 10:30 AM, Surveyor interviewed Director A. Surveyor asked Director A if Director A had received any concerns from residents, staff, or family members over the past few months. Director A reported, "We had to call the police on [Family Member D], the son of [Resident 1]. We called the police on [Family Member D] two times in 24 hours in January 2024." Director A verified the facility called the police on Family Member D on 01/08/2024 and 01/09/2024 because Family Member D "wasn't following the visiting policy." Director A indicated that visiting hours were between 8:00 AM and 8:00 PM but exceptions could be made if needed. Director A stated, "[Family Member D] would sometimes stay here until 3:00 AM or 4:00 AM. [Caregiver E] told [Family Member D] 'you need to leave.' [Family Member D] was in the building after 10:00 PM (on 01/08/2024). [S/he] was always pretty quiet. You never knew [s/he] was here." Surveyor asked Director A if an incident report was available. Director A provided Surveyor with a copy of the facility's internal	N 356		

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N 356	Continued From page 2	N 356		

investigation, including incident reports, dated 01/08/2024 and 01/10/2024, staff statements, and incident reports from Minocqua Police Department.

A "Resident/Visitor Incident Report," dated 01/08/2024, noted that [Resident 1's] [son/daughter] was in Resident 1's room at 10:00 PM, past visiting hours. Staff and told [him/her] that [s/he] needed to leave the building.

According to an internal investigation, Director A noted, "On the evening of 1/9/24 [sic] I received a call from staff that res [sic] [son/daughter] was again in the building. Was not seen coming in. At 8 pm [sic] they went to the res [sic] room to remind [son/daughter] that visiting hours were about over. [Son/Daughter] was on [his/her] way out yelling 'does everyone see I am leaving at exactly 8 pm! This is [expletive, expletive]!!' and slammed the front door."

On 01/24/2024 at 3:11 PM, Surveyor interviewed Caregiver B. Caregiver B reported that Resident 1's [son/daughter] visited on 01/08/2024 and [Caregiver E] told Resident 1's [son/daughter] to leave. Caregiver B indicated that there was no specific policy for visiting hours and sometimes [Family Member D] visited as late as 3:00 AM. Caregiver B reported, "[Family Member D] was not creating any issues or being loud; [S/He] was just sitting in [Resident 1's] room on 01/08/2024."

On 01/29/2024 at 2:00 PM, Surveyor interviewed Caregiver C. Caregiver C reported, "Staff asked [Family Member D] to leave earlier on 01/08/2024. Visiting hours were over. Staff went back to tell [Family Member D] to leave. [S/He] knows visiting hours are over at 8:00 PM." Caregiver C reported that Family Member D had

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N 356	Continued From page 3 a history of causing a "disturbance while visiting and family dynamics were not the best." Surveyor asked Caregiver C if Family Member D caused any problems while visiting on 01/08/2024. Caregiver C stated that s/he was not sure if there were any issues or concerns with Family Member D before being told to leave on 01/08/2024. The provider restricted visiting hours for Resident 1 on 01/08/2024 and 01/09/2024.	N 356		
{N 399}	83.36(2) Maintain current written staffing schedule Staffing schedule. The CBRF shall maintain a current written schedule for staffing the CBRF. The schedule shall include each employee ' s full name, job assignment and time worked. This Rule is not met as evidenced by: Based on interview and record review, the provider did not maintain an accurate written schedule for staffing the community based residential facility (CBRF). This is a repeat deficiency. See Statement of Deficiency (SOD) NB6611, dated 08/09/2023. Findings include: The provider is licensed to care for up to 10 residents in the following client groups: physically disabled, irreversible dementia/Alzheimer's disease, terminally ill, and advanced age. The facility is connected to the provider's licensed CBRF, Country Terrace Minocqua I (side A). The two CBRFs (side A and side B) have a shared entrance, lounge area, dining room, and kitchen.	{N 399}		

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{N 399}	Continued From page 4 On 01/24/2024 at 10:30 AM, Surveyor interviewed Director A. Surveyor asked Director A about staffing. Director A indicated 3 to 4 staff worked AM shift (6 AM - 2 PM), 3 staff worked PM shift (2 PM - 10 PM) and 2 to 3 staff worked NOC (overnight) shift (10 PM - 6 AM). Director A reported that staff worked on both sides (side A and side B) of the building. On 01/24/2024, Surveyor reviewed staff schedules for November and December 2023 and January 2024. The schedules indicated they were for facility #33. The schedules did not indicate if staff worked in Country Terrace Minocqua I (side A) or Country Terrace Minocqua II (side B). On 01/29/2024 at 2:00 PM, Surveyor interviewed Caregiver C. Caregiver C reported, "We work the whole building during our shifts." Caregiver C indicated that if 4 staff work, 2 staff work on side A and 2 staff work on side B; If 3 staff work, 2 staff work on side A and 1 staff works on side B. Caregiver C noted, "We cross over and help as needed." On 01/29/2024 at 3:01 PM, Director A confirmed the following via email: the schedule is set up for the whole building (not separated for side A or side B). If 4 staff work, 2 staff work on side A with one of the staff as a medication passer, and two of the staff work on side B with one of the staff as a medication passer. If 3 staff works, one of the staff work on side A, 2 staff work on side B, and one staff is a medication passer. The provider did not maintain an accurate schedule to identify which staff were working in each CBRF.	{N 399}		

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